NATIONAL MEDICAL SUPPORT NOTICE

PART A

NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (EIRSA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998.

Issuing Agency: SAN DIEGO DCSS Issuing Agency Address: PO BOX 122031, SAN DIEGO, CA 92112-2031 Date of Notice: 01/12/2012 Case Number: 2XXXXXXXXXXXXXX Telephone Number: (866) 901-3212 FAX Number: (619)236-4426	Court or Administrative Authority: SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO Date of Support Order: 02/03/2004 Support Order Number: DFXXXXXX

XXXXXXXX)
Employer/Withholder's Federal EIN Number

ABC COMPANY)
Employer/Withholder's Name

123 MAIN STREET
SAN DIEGO, CA 99999)
Employer/Withholder's Address

)
Custodial Parent's Name (Last, First, MI)

)
Custodial Parent's Mailing Address

)
Child(ren)'s Mailing Address (if different from Custodial Parent's)[x]

)
)
)
Name, Mailing Address, and Telephone Number of a Representative of the Child(ren)

RE* DOE, JOHN
Employee's Name (Last, First, MI)

999-99-9999
Employee's Social Security Number

1234 ELM STREET APT 5
SAN DIEGO, CA 99999
Employee's Mailing Address

COUNTY OF SAN DIEGO DEPARTMENT
OF CHILD SUPPORT SERVICES
PO BOX 122031
SAN DIEGO, CA 92112-2031
Substituted Official/Agency Name and Address

Child(ren)'s name(s)	DOB	SSN	Child(ren)'s Name(s)	DOB	SSN
ROSIE DOE	01/01/1990	888-88-8888			
LILLI DOE	01/01/1991	777-77-7777			

The order requires the child(ren) to be enrolled in: ☐ any health coverages available; or ☐ only the following coverage(s): X Medical; X Dental; X Vision; __Prescription drug; __Mental health; __Other (specify):

EMPLOYER RESPONSE

If either 1,2, or 3 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If neither 1, 2, nor 3 applies, forward Part B to the appropriate plan administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. Check number 4 and return this Part A to the Issuing Agency if the Plan Administrator informs you that the child(ren) is/are enrolled in an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization.

1. Employer does not maintain or contribute to plans providing dependent or family health care coverage.
2. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes.
3. Health care coverage is not available because employee is no longer employed by the employer.

   Date of termination: _____

   Last known address: _____

   Last known telephone number: _____

   New employer (if known): _____

   New employer address: _____

   New employer telephone number: _____

4. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.

Employer Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

EIN (if not provided by Issuing Agency on Notice to Withhold for Health Care Coverage):

JOHN DOE 2XXXXXXXXXXXXXXX ABC COMPANY

PART B
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974, and State and local government and church plans, Sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law.

Issuing Agency: SAN DIEGO DCSS Issuing Agency Address: PO BOX 12031, SAN DIEGO CA 92112-2031 Date of Notice: 01/12/2012 Case Number: 2XXXXXXXXXXXXXX Telephone Number: (866) 901-3212 FAX Number: (619) 236-4426	Court or Administrative Authority: Superior Court of California, County of San Diego Date of Support Order: 02/03/2004 Support Order Number: DFXXXXXX

xxxxxxxxx
Employer/Withholder's Federal EIN Number

RE: DOE, JOHN
Employee's Name (last, First, MI)

ABC COMPANY
Employer/Withholder's Name

999-99-9999
Employee's Social Security Number

123 MAIN STREET
SAN DIEGO, CA 999999
Employer/Withholder's Address

1234 ELM STREET APT 5
SAN DIEGO, CA 999999
Employee's Address

Custodial Parent's Name (Last, First, MI)

County of San Diego Department of Child Support Services
PO BOX 122031
San Diego CA 92112-2031
Substituted Official/Agency Name and Address

Custodial Parent's Mailing Address

Child(ren)'s Mailing Address (if different from Custodial Parent's)

Name(s), Mailing Address, and Telephone Number of a Representative of the child(ren)

Child(ren)'sName's	DOB	SSN	Child(ren)'s Name(s)	DOB	SSN
ROSIE DOE	01/01/1990	888-88-8888			
LILLI DOE	01/01/1991	777-77-7777			

The order requires the child(ren) to be enrolled in ☐ any health coverages available; or ☐ only the following coverage(s): X Medical X Dental X Vision ___ Prescription drug ___Mental Health; ___Other (specify):_____

PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice or sooner if reasonable)

This Notice was received by the plan administrator on _____.

1. This Notice was determined to be a "qualified medical child support order," on_____. Complete **Response 2 or 3, and 4,** if applicable.
2. The participant (employee) and alternate recipients(s) (child(ren)) are to be enrolled in the following coverage.
   a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
   b. There is only one type of coverage provided under the plan. The child(ren) is/are included as a dependents of the participant under the plan.
   c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
   d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of __/__/____ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option: _____. Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

3. There is more than one option available under the plan and the participant is not enrolled. The issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any:_____.
4. The participant is subject to a waiting period that expires __/__/___(more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe her: _____). At the completion of the waiting period, the plan administrator will process the enrollment.
5. This Notice does not constitute a "qualified medical child support order" because:
   The name of the child(ren) or participant is unavailable.
   The mailing address of the child(ren) (or a substituted official) or participant is unavailable.
   The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under plan _____(insert name(s) of child(ren).

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address: _____

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):	FOR COURT USE ONLY
TELEPHONE NO: FAX NO: (Optional): E-MAIL ADDRESS (Optional): ATTORNEY FOR (Name):	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO STREET ADDRESS: 220 W BROADWAY RM 4005 MAILING ADDRESS: 220 W BROADWAY RM 4005 CITY AND ZIP CODE: SAN DIEGO 92101-3886 BRANCH NAME: CENTRAL DIVISION (FAMILY)	
PETITIONER/PLANTIFF: **COUNTY OF SAN DIEGO** RESPONDENT/DEFENDANT: **DOE, JOHN** OTHER PARENT:	
REQUEST AND NOTICE OF HEARING REGARDING HEALTH INSURANCE ASSIGNMENT	CASE NUMBER: **DFXXXXXX**

NOTICE: If you object to the Application and Order for Health Insurance Coverage(form FL-470) or National Medical Support Notice (form OMB-0970-0222), complete and file this form with the court clerk to request a hearing. This form may not be used to modify your current child support amount. (See "information Sheet on Changing a Child Support Order" on page 2 of form FL-192.)

1. A hearing on this application will be held as follows (see instructions for getting a hearing date on form FL-478-INFO):

a. Date: Time: ☐ Dept: ☐ Div.: ☐ Room:

b. The address of the court is: ☐ same as above ☐ other (specify)

2. ☐ I request that service of the *Application and Order for Health Insurance Coverage (*form FL-470) or National Medical Support Notice (form OMB-0970- 0222) be quashed (set aside) because:

a. ☐ I am not the obligor named in the *Application and Order for Health Insurance Coverage or National Medical Support Notice.*

b. ☐ Health insurance coverage is not available at a reasonable cost.

c. ☐ The Health insurance premium plus the monthly payment in any earnings assignment order are more than half of my total net income each month from all sources.

d. ☐ The following children (name):

e. ☐ I was not notified at least 15 days before the date of filing of the application that a health insurance coverage assignment was being sought.

f. ☐ No order to maintain health insurance has been issued.

g. ☐ Health insurance coverage is or will be provided for the children, but not through a parent's job-related coverage (explain):

h. ☐ The employer's choice of coverage is inappropriate (explain):

i. ☐ Other (specify)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date:

_____ ▶ _____

(TYPE OR PRINT NAME OF PERSON REQUESTING HEARING) (SIGNATURE OF PERSON REQUESTING HEARING)

Form Adopted for Mandatory Use Judicial Council of California
FL-478 (New January 1, 2007)

REQUEST AND NOTICE OF HEARING REGARDING HEALTH INSURANCE ASSIGNMENT (Family Law – Governmental – UIFSA)

Family Code, §§ 3761, 3765, and 3773
www. Courting.ca.gov

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF CHILD SUPPORT SERVICES

TERMINATION OF BENEFITS/EMPLOYMENT NOTICE
DCSS0114 (08/19/05)

TO: ABC COMPANY
123 MAIN STREET
SAN DIEGO, CA 999999

DATE: 01/12/2012
PHONE: (866) 901-3212
EMPLOYE: JOHN DOE

FROM: COUNTY OF SAN DIEGO DEPARTMENT OF CHILD SUPPORT SERVICES
PO BOX 12031
SAN DIEGO CA 92112-2031

SSN: 999-99-9999
DOB: 01/01/1951

Participant
Number: 2XXXXXXXXXXXXXXXXXX

TERMINATION OF BENEFITS/EMPLOYMENT NOTICE

INSTRUCTIONS: **Use this form to report termination of employment or benefits of an employee for whom you have a requirement to withhold support and/or provide health benefits.**

Termination of: ☐ Employment ☐ Health Benefits ☐ Both

DATE OF TERMINATION-BENEFITS	REASON FOR TERMINATION	
COBRA HEALTH INSURANCE AVAILABLE: ☐ NO ☐ YES, coverage thru: _____ DATE		
DATE OF TERMINATION- EMPLOYMENT	REASON FOR TERMINATION	SUBJECT TO REHIRE? ☐ NO ☐ YES
LAST KNOWN HOME ADDRESS (Street address, City, State, Zip code)		TELEPHONE NUMBER
NEW EMPLOYER'S NAME (If know)		TELEPHONE NUMBER
NEW EMPLOYER'S ADDRESS (If known – Street address, City, State, Zip code)		

CERTIFICATION OF RECORD

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____
SIGNATURE DATE

_____
PRINTED NAME

_____
TITLE